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Does Comfort Care Make You Uncomfortable? Use of the CARES Tool for End-of-Life Symptom Assessment and Management

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Abstract

Acute care nurses caring for end-of-life (EOL) patients often feel unprepared for andundereducated about this high-need population. According to current literature, many nurses lack adequate training in providing EOL care. This project aimed to improve symptom management of dying patients by providing acute care nurses education about EOL symptom assessment and medication use for symptom management. The revised Iowa model, which emphasizes clinician involvement, guided this evidence-based practice project. Sixteen acute care nurses received 30-minute in-person education, consisting of instruction in EOL symptom assessment and management via use of the CARES (comfort, airway, restlessness, emotional, self-care) tool and basic pharmacology review of common medications used for EOL symptom management. The thanatophobia scale was administered before, immediately after, and 1 month following the educational session to evaluate nurses' uncomfortable feelings and sense of helplessness when caring for EOL patients. A benefit of the intervention appeared to be a decrease (though not a statistically significant decrease) in these negative feelings, which may have improved symptom management. Doses of medications used for symptom management in the last days of life were counted via electronic medical record review before and after education. Statistical analysis was not conducted due to the low number of doses. However, medication doses for symptom management appeared to increase after the educational session. The outcomes of this project support the necessity of EOL symptom management education for nurses.

Keywords: comfort care, nurse education, end-of-life, symptom management

Does Comfort Care Make You Uncomfortable? Use of the CARES Tool for End-of-Life Symptom Assessment and Management

Bedside nurses bear the weight of caring for hospitalized patients at the end of life (EOL). In addition to aggressive symptom monitoring and management, nurses are responsible for navigating emotional and spiritual support resources for the patient and family. These demands stretch the boundaries of nursing comfort and education on patient care during this life transition. Ferrell et al. (2016) found the key components of palliative care identified by the National Consensus Project Guidelines for Palliative Care and the End of Life Nursing Education Consortium training curriculum were inconsistently covered during primary nursing education. If a significant percentage of acute care nurses do not feel comfortable or are not adequately educated to care for patients in this stage of life, symptom management quality decreases (Powazki et al., 2014). In 2018, 793,000 hospital deaths occurred among adults aged 25 or older (Centers for Disease Control and Prevention, 2020), emphasizing the importance of addressing this problem. Additionally, lower quality ratings for EOL care are associated with nurses working in a poor practice environment, defined by Lasater et al. (2018) as high workloads, limited clinical authority, and lack of interdisciplinary support. Cheong et al. (2020) viewed death education as a key element for the transition to better quality EOL nursing care.

Understanding the needs of nurses caring for EOL patients, Freeman (2013) developed the CARES (Comfort, Airway, Restlessness and delirium, Emotional and spiritual support and Self-care) tool. This reference, based on the most common symptom management needs of dying patients (Freeman et al., 2015), provides educational reminders about symptom management at EOL. Instruction in the use of the CARES tool assists nurses to act as advocates in providing compassionate, evidence-based care for the dying (Freeman et al., 2015).

Purpose

The unfortunate common problem of poorly managed symptoms in dying patients highlights the challenges acute care nurses face when managing EOL patients and the patients' unintended suffering. Nurses must address the physical and emotional demands of caring for high-need EOL patients in tandem with focusing on other patients with a curative goal. A literature review demonstrated that foundational nursing education provides minimal training in EOL care. Additionally, acute care nurses do not feel adequately educated about or supported when caring for this population. The author's experience as a palliative nurse practitioner providing support for EOL patients and witnessing the need for nursing education and support in this area are the driving forces behind this project.

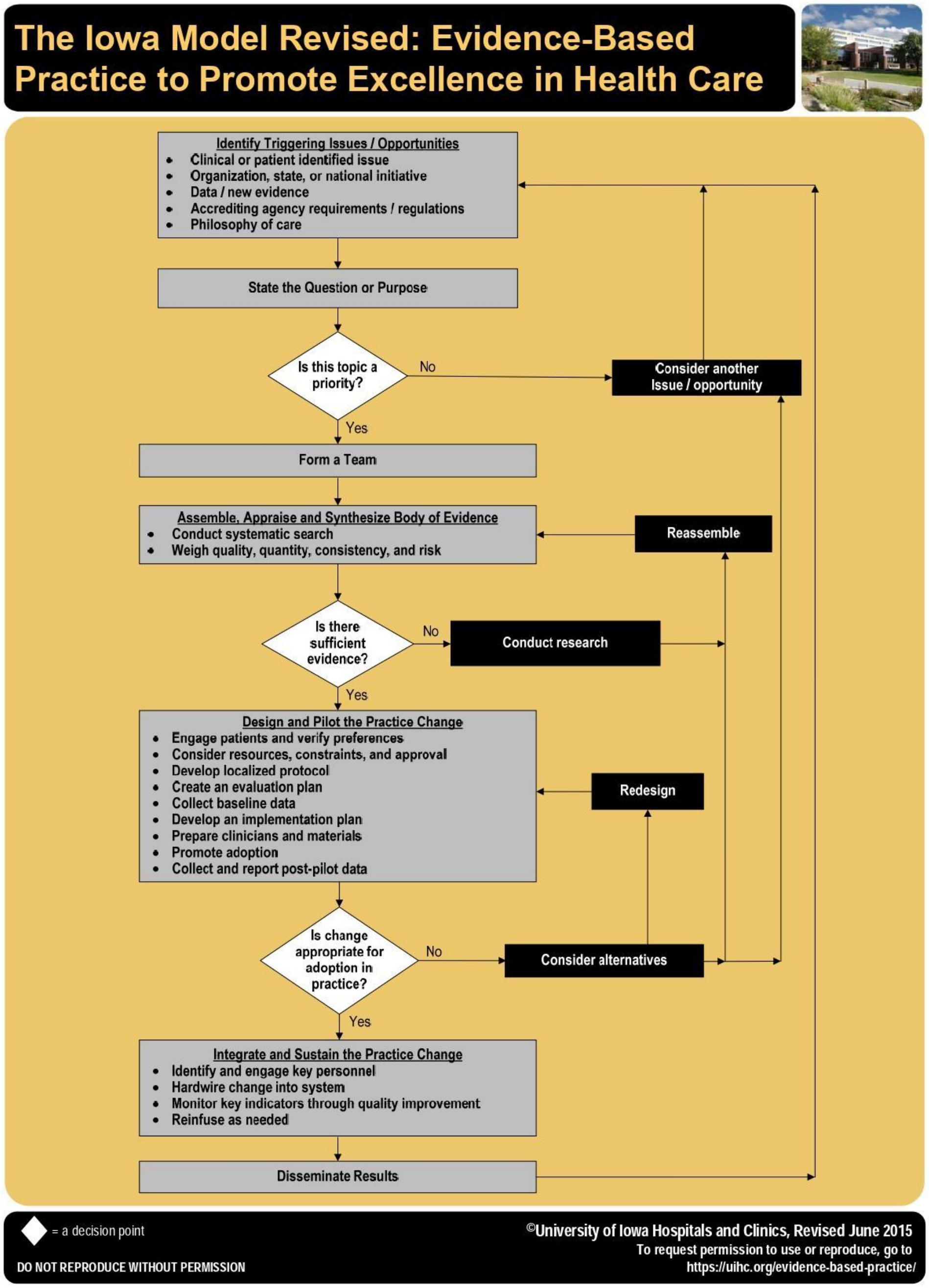
Based on the evaluation of this problem, a PICOT question was developed: In EOL patients admitted to an acute care hospital, how does nursing education on the use of the CARES tool and EOL symptom management compare to current practices of nurses assigned to care for EOL patients without explicit EOL education, and improve nursing comfort in caring for dying patients and managing EOL symptoms over 1 month?

Evidence-Based Practice Model

Reflecting on the multiple models of evidence-based practice (EBP) implementation, the revised Iowa model (Iowa Model Collaborative, 2017) was selected to guide this EBP change project (see Figure 1). First, the model compels users to focus on a precise problem in relation to a patient population (in this instance, poor symptom management of dying patients), then determine if the issue is significant enough to ensure availability of support and resources to implement and sustain an EBP change. A critical factor is engaging individuals

Figure 1

The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care



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who will be affected by the practice change to participate on the EBP change team and embrace the new way of practice (Steelman, 2015). Next, a literature review is completed; if the evidence is deemed sufficient to make a practice change, an implementation plan is designed and piloted. The revised Iowa model explicitly recommends implementing a pilot process to address any needed adjustments and determine if the intervention is feasible before implementing a systemic change (Iowa Model Collaborative, 2017).

Literature Review

A literature review was conducted to support this intervention by searching PubMed, the Cumulative Index to Nursing and Allied Health Literature, and Google Scholar using the following key terms: end of life, end of life care, comfort care, imminently dying, palliative care, symptom assessment, symptom management, nursing knowledge, nursing comfort, nursing education, nursing role, hospitalized patients, acute care setting, and inpatient. The articles were limited to those published in the last 7 years, printed in English, and focused primarily on adult patients. This search led to selection and evaluation of seven manuscripts.

The overarching theme through current literature was that nurses caring for actively dying patients in an acute care setting felt unprepared for and undereducated in giving care to this high-need population (Karbasi et al., 2018; O’Shea & Mager, 2019; Puente-Fernández et al., 2020; Sekse et al., 2018; Stacy et al., 2019). Several studies supported the idea that EOL symptoms are often poorly controlled due to lack of time, preparation, and nursing education (Karbasi et al., 2018; Lai et al., 2018; Puente-Fernández et al., 2020; Sekse et al., 2018).

Through a metasynthesis of 28 articles, Sekse et al. (2018) conceptualized the nurse’s role in caring for dying patients as a spider in a web, holding the components of patient care together. Nurses’ feelings of immense pressure without additional support, combined with their documented perceptions of lacking knowledge and training on EOL care, contributed to patient suffering at EOL (Sekse et al., 2018). The strengths of this metasynthesis include a focus on nurses' evaluation of personal needs and abilities, which provides clear direction for practical initiatives and research. Limitations include the possibility of missing important articles in the literature search and a wide geographical and cultural variability of the included studies.

Puente-Fernández et al. (2020) completed a systematic review to determine nursing professionals' attitudes, strategies, and care practices toward death. Critical evaluation of 17 qualitative studies demonstrated lack of training in EOL care caused nurses to experience feelings of inadequacy and a lack of confidence when caring for dying patients. These studies showed the death and dying process substantially impacted acute care nurses by causing distress and generating emotions that negatively influenced EOL care and nurses' well-being. Additionally, nurses experienced emotional disconnection with—and avoidance of—patients and their families, leading to painful and undignified patient deaths. Puente-Fernández et al. (2020) determined that to avoid the emotional exhaustion associated with caring for dying people, appropriate nurse education and support are essential. A limitation of this review is the scarcity of available studies focused on nursing attitudes toward death; however, the authors included two metasyntheses, which strengthened findings.

O'Shea and Mager (2019) completed a cross-sectional study of 57 nurses to evaluate the effectiveness of an EOL education program on the knowledge of and attitudes toward caring for patients with advanced illness or at EOL. A thanatophobia scale (TS; Merrill et al., 1998) was given pre and posteducation to measure change in attitudes toward caring for dying patients. The education helped nurses identify areas of needed improvement and elevated nurses' confidence in their ability to identify patient needs. Inadequate knowledge was a significant barrier to providing high quality EOL care. Encouragingly, most respondents noted after the education that they intended to change their practice; however, self-reported intent does not indicate actual change (Sheeran et al., 2016) and this study did not allow for evaluation of change in providing EOL care after education. A low response rate and a short time frame of 1 month for survey completion may have affected validity. Additionally, the researchers focused on measuring nurses' "attitudes toward caring for dying patients" (O'Shea & Mager, 2019, p. 2), but the TS was designed to measure "uncomfortable feelings and sense of helplessness" (Merrill et al., 1998, p. 83).

A qualitative study by Lai et al. (2018) explored 26 healthcare providers' (including 13 nurses) experiences in providing EOL care in nonpalliative settings. Nurses expressed several difficulties in providing EOL care: lack of support, lack of effective interventions to manage symptoms, and inability to resolve EOL suffering using their skill set. These difficulties led to nurses' perceptions of poor quality of patient death. Although this study's strengths include components such as demonstration of gaps in research and education supporting EOL care, the cultural relevance to nurses in the United States may be limited as the nurses in this study lived and worked in China. Moreover, recruitment was conducted via social media, which may have contributed to the lack of diverse inclusion of nurses, including veteran nurses who may not access technology as often.

Powazki et al. (2014) completed a cross-sectional mixed-method study based on a two-part questionnaire to evaluate nurses' self-described ability and comfort with EOL care to determine if nurses' comfort or ability was associated with specific demographic characteristics, and assess clinical barriers to implementing best nursing practices. An analysis of 123 surveys determined older nurses with more experience and ongoing specialized education were more likely to have higher self-described ability and comfort levels when caring for EOL patients. Interestingly, there was no correlation between education level and degree of comfort in caring for EOL patients. The study protocol did not provide for the ability to determine the demographics of nurses who completed the questionnaire and those who did not. Also, the placement of neutral responses to survey questions in the negative category for statistical analysis may have influenced study results. Furthermore, completion of the study in an academic medical center may make generalizability outside that setting unreliable. Development of an EOL toolkit to support nurses caring for EOL patients is a notable outcome of this study.

Karbasi et al. (2018) organized a mixed studies review of 19 manuscripts to determine nurses' perceptions of personal knowledge, skills, and experiences in caring for EOL patients, and to assess knowledge gaps and educational needs. Themes of nursing self-identity while caring for EOL patients included protector, advocate, and reflective caregiver. The review also identified several obstacles to high-level EOL care, most notably nurses' lack of education and knowledge related to psychosocial, emotional, and spiritual symptom management at EOL. Time constraints and divided focus were additional barriers to quality EOL care. Supportive measures for quality EOL care included clear communication, having a known plan of care, and education focused on symptom management at EOL. Possible omission of relevant articles and a focus on critical care nurses instead of all inpatient nurses are limitations. However, this review included rigorous analysis and the inclusion of a variety of study types, making the information applicable in multiple settings.

Stacy et al. (2019) evaluated the effectiveness of the CARES tool (Freeman, 2013) in increasing nurse knowledge and comfort in providing EOL care. Using a quasi-experimental study, nine nurses completed a pre and posteducational intervention survey to evaluate their knowledge and comfort in caring for EOL patients. Five of the nine areas assessed yielded statistically significant improvements, demonstrating EOL education and use of the CARES tool improved nurses' comfort with EOL care and symptom management in dying patients. A small sample size may affect the validity of results. Additionally, the participants consisted of nurses on units with an increased number of EOL patients, which could lead to bias as these nurses may previously have had an increased level of comfort when caring for EOL patients.

This literature review yielded overwhelming evidence that many nurses caring for EOL patients in acute care settings lack the experience and knowledge to effectively provide this level of care (Karbasi et al., 2018; O'Shea & Mager, 2019; Puente-Fernández et al., 2020; Sekse et al., 2018; Stacy et al., 2019). EOL education may help empower health professionals to change clinical practice. Providing high-quality, evidence-based EOL care can be accomplished by using the CARES tool and providing additional symptom management education (Freeman et al., 2015; see also Karbasi et al., 2018; Lai et al., 2018; Puente-Fernández et al., 2020; Sekse et al., 2018). Attitudes, norms, and self-efficacy show a causal effect on intention and behavior, and interventions that positively influence these thoughts can foster behavior change (Sheeran et al., 2016).

Method

This evidence-based project was initiated by informing acute care nurses on a med-surg unit that an advanced practice nurse specializing in palliative care would be providing education sessions focused on symptom management of dying patients. If nurses were interested, they could present to the advanced practice nurse within the specified time frame for education. Sixteen nurses participated.

Before an educational session, nurses completed a TS (Merrill et al., 1998). The validated TS (Mason & Ellershaw, 2004) is designed as a 7-point Likert scale and assesses uncomfortable feelings and sense of helplessness when caring for dying patients (see Figure 2). As demonstrated in the literature review, these feelings are commonly expressed by nurses caring for this patient population.

Figure 2

Thanatophobia Scale

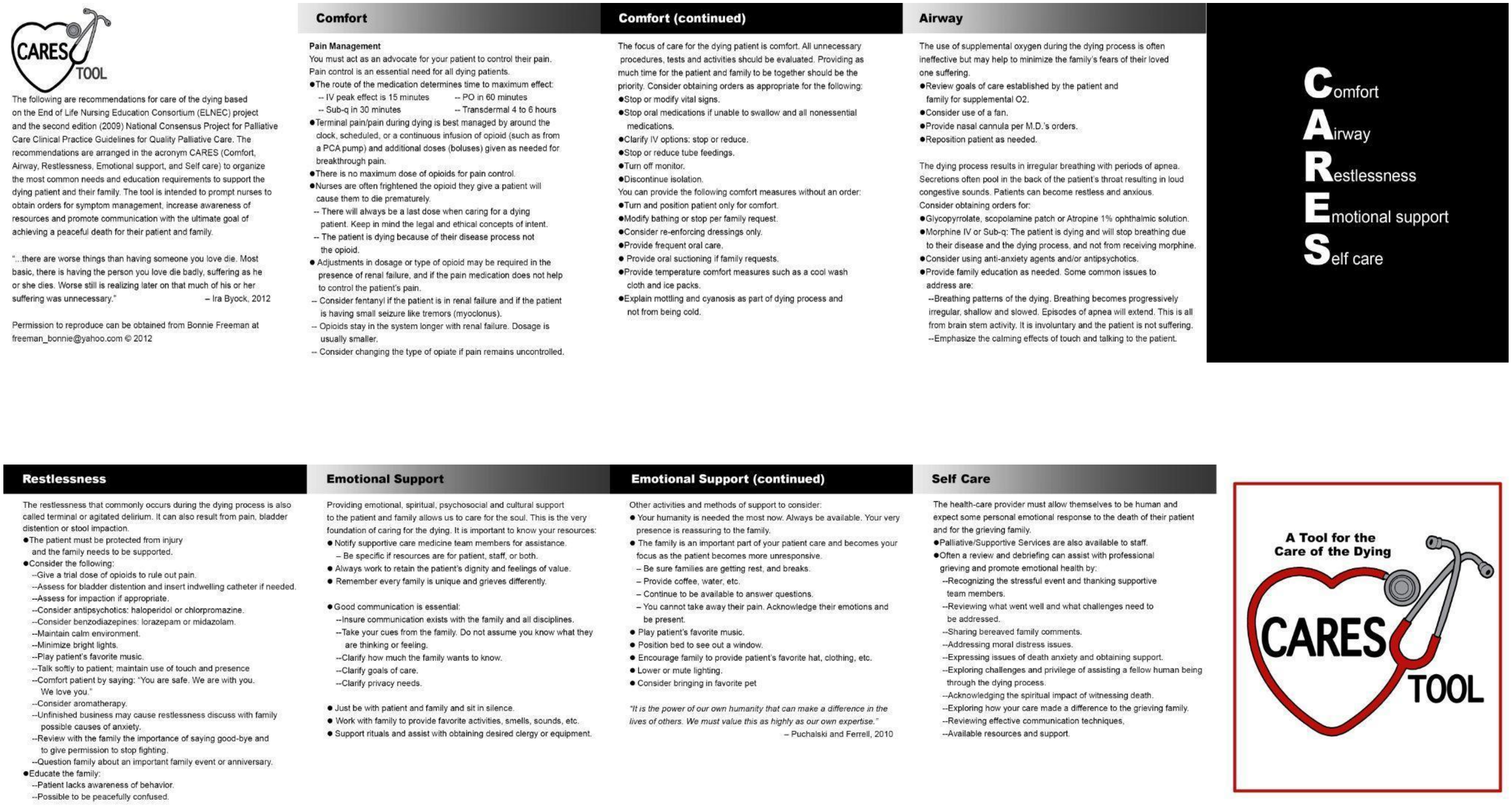
		Very strongly disagree	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Very strongly agree
Q1	Dying patients make me feel uneasy	1	2	3	4	5	6	7
Q2	I feel pretty helpless when I have terminal patients on my ward	1	2	3	4	5	6	7
Q3	It is frustrating to have to continue talking with relatives of patients who are not going to get better	1	2	3	4	5	6	7
Q4	Managing dying patients traumatizes me	1	2	3	4	5	6	7
Q5	It makes me uncomfortable when a dying patient wants to say goodbye to me	1	2	3	4	5	6	7
Q6	I don't look forward to being the personal nurse of a dying patient	1	2	3	4	5	6	7
Q7	When patients begin to discuss death, I feel uncomfortable	1	2	3	4	5	6	7

Note. Adapted from Merrill, J., Lorimer, R., Thornby, J., & Woods, A. (1998). Caring for terminally ill persons: Comparative analysis of attitudes (thanatophobia) of practicing physicians, student nurses, and medical students. *Psychological Reports*, *83*(5), 123–129.

After completing the TS, nurses participated in a 30-minute in-person presentation that included an instructional review of the CARES tool (Freeman, 2013; see Figure 3), and basic pharmacology of medications used for EOL symptom management. Nurses were reevaluated using the TS immediately after education and 4 weeks later to determine if their level of

Figure 3

CARES tool



CARES TOOL

The following are recommendations for care of the dying based on the End of Life Nursing Education Consortium (ELNEC) project and the second edition (2009) National Consensus Project for Palliative Care Clinical Practice Guidelines for Quality Palliative Care. The recommendations are arranged in the acronym CARES (Comfort, Airway, Restlessness, Emotional support, and Self care) to organize the most common needs and education requirements to support the dying patient and their family. The tool is intended to prompt nurses to obtain orders for symptom management, increase awareness of resources and promote communication with the ultimate goal of achieving a peaceful death for their patient and family.

"...there are worse things than having someone you love die. Most basic, there is having the person you love die badly, suffering as he or she dies. Worse still is realizing later on that much of his or her suffering was unnecessary." – Ira Byock, 2012

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Comfort

Pain Management

You must act as an advocate for your patient to control their pain. Pain control is an essential need for all dying patients.

●The route of the medication determines time to maximum effect:
  -- IV peak effect is 15 minutes -- PO in 60 minutes
  -- Sub-q in 30 minutes -- Transdermal 4 to 6 hours
●Terminal pain/pain during dying is best managed by around the clock, scheduled, or a continuous infusion of opioid (such as from a PCA pump) and additional doses (boluses) given as needed for breakthrough pain.
●There is no maximum dose of opioids for pain control.
●Nurses are often frightened the opioid they give a patient will cause them to die prematurely.
  -- There will always be a last dose when caring for a dying patient. Keep in mind the legal and ethical concepts of intent.
  -- The patient is dying because of their disease process not the opioid.
● Adjustments in dosage or type of opioid may be required in the presence of renal failure, and if the pain medication does not help to control the patient's pain.
  -- Consider fentanyl if the patient is in renal failure and if the patient is having small seizure like tremors (myoclonus).
  -- Opioids stay in the system longer with renal failure. Dosage is usually smaller.
  -- Consider changing the type of opiate if pain remains uncontrolled.

Comfort (continued)

The focus of care for the dying patient is comfort. All unnecessary procedures, tests and activities should be evaluated. Providing as much time for the patient and family to be together should be the priority. Consider obtaining orders as appropriate for the following:

●Stop or modify vital signs.
●Stop oral medications if unable to swallow and all nonessential medications.
●Clarify IV options: stop or reduce.
●Stop or reduce tube feedings.
●Turn off monitor.
●Discontinue isolation.

You can provide the following comfort measures without an order:

●Turn and position patient only for comfort.
●Modify bathing or stop per family request.
●Consider re-enforcing dressings only.
●Provide frequent oral care.
● Provide oral suctioning if family requests.
●Provide temperature comfort measures such as a cool wash cloth and ice packs.
●Explain mottling and cyanosis as part of dying process and not from being cold.

Airway

The use of supplemental oxygen during the dying process is often ineffective but may help to minimize the family's fears of their loved one suffering.

●Review goals of care established by the patient and family for supplemental O2.
●Consider use of a fan.
●Provide nasal cannula per M.D.'s orders.
●Reposition patient as needed.

The dying process results in irregular breathing with periods of apnea. Secretions often pool in the back of the patient's throat resulting in loud congestive sounds. Patients can become restless and anxious.
Consider obtaining orders for:

●Glycopyrrolate, scopolamine patch or Atropine 1% ophthalmic solution.
●Morphine IV or Sub-q: The patient is dying and will stop breathing due to their disease and the dying process, and not from receiving morphine.
●Consider using anti-anxiety agents and/or antipsychotics.
●Provide family education as needed. Some common issues to address are:
  --Breathing patterns of the dying. Breathing becomes progressively irregular, shallow and slowed. Episodes of apnea will extend. This is all from brain stem activity. It is involuntary and the patient is not suffering.
  --Emphasize the calming effects of touch and talking to the patient.

Comfort
Airway
Restlessness
Emotional support
Self care

Restlessness

The restlessness that commonly occurs during the dying process is also called terminal or agitated delirium. It can also result from pain, bladder distention or stool impaction.

●The patient must be protected from injury and the family needs to be supported.
●Consider the following:
  --Give a trial dose of opioids to rule out pain.
  --Assess for bladder distention and insert indwelling catheter if needed.
  --Assess for impaction if appropriate.
  --Consider antipsychotics: haloperidol or chlorpromazine.
  --Consider benzodiazepines: lorazepam or midazolam.
  --Maintain calm environment.
  --Minimize bright lights.
  --Play patient's favorite music.
  --Talk softly to patient; maintain use of touch and presence
  --Comfort patient by saying: "You are safe. We are with you. We love you."
  --Consider aromatherapy.
  --Unfinished business may cause restlessness discuss with family possible causes of anxiety.
  --Review with the family the importance of saying good-bye and to give permission to stop fighting.
  --Question family about an important family event or anniversary.
●Educate the family:
  --Patient lacks awareness of behavior.
  --Possible to be peacefully confused.

Emotional Support

Providing emotional, spiritual, psychosocial and cultural support to the patient and family allows us to care for the soul. This is the very foundation of caring for the dying. It is important to know your resources:

● Notify supportive care medicine team members for assistance.
  – Be specific if resources are for patient, staff, or both.
● Always work to retain the patient's dignity and feelings of value.
● Remember every family is unique and grieves differently.

●Good communication is essential:
  --Insure communication exists with the family and all disciplines.
  --Take your cues from the family. Do not assume you know what they are thinking or feeling.
  --Clarify how much the family wants to know.
  --Clarify goals of care.
  --Clarify privacy needs.

● Just be with patient and family and sit in silence.
● Work with family to provide favorite activities, smells, sounds, etc.
● Support rituals and assist with obtaining desired clergy or equipment.

Emotional Support (continued)

Other activities and methods of support to consider:

● Your humanity is needed the most now. Always be available. Your very presence is reassuring to the family.
● The family is an important part of your patient care and becomes your focus as the patient becomes more unresponsive.
  – Be sure families are getting rest, and breaks.
  – Provide coffee, water, etc.
  – Continue to be available to answer questions.
  – You cannot take away their pain. Acknowledge their emotions and be present.
● Play patient's favorite music.
● Position bed to see out a window.
● Encourage family to provide patient's favorite hat, clothing, etc.
● Lower or mute lighting.
● Consider bringing in favorite pet

"It is the power of our own humanity that can make a difference in the lives of others. We must value this as highly as our own expertise."
– Puchalski and Ferrell, 2010

Self Care

The health-care provider must allow themselves to be human and expect some personal emotional response to the death of their patient and for the grieving family.

●Palliative/Supportive Services are also available to staff.
●Often a review and debriefing can assist with professional grieving and promote emotional health by:
  --Recognizing the stressful event and thanking supportive team members.
  --Reviewing what went well and what challenges need to be addressed.
  --Sharing bereaved family comments.
  --Addressing moral distress issues.
  --Expressing issues of death anxiety and obtaining support.
  --Exploring challenges and privilege of assisting a fellow human being through the dying process.
  --Acknowledging the spiritual impact of witnessing death.
  --Exploring how your care made a difference to the grieving family.
  --Reviewing effective communication techniques,
  --Available resources and support.

A Tool for the Care of the Dying

CARES TOOL

Note. The tool is intended to support nurses in managing symptoms and increase awareness of resources (Freeman et al., 2013) uncomfortable feelings and sense of helplessness when caring for dying patients changed after the educational session and over time.

Electronic medical record review provided the number of symptom management medication doses given to the EOL patients (n=11) on the unit who had a comfort focused care order set placed within 30 days posteducation. Patients with this order set are expected to die within hours to days. Medication doses were counted from the onset of comfort care orders, but no more than 72 hours before death or discharge. The number of medication doses per patient was compared with that of patients (n=9) on the same unit who had a comfort care order set during the same 30-day period 1 year prior to determine if there was an increase in the number of symptom management medication doses provided to EOL patients after the educational session.

Ethical Considerations

Hospital administration was informed of the project and provided preliminary authorization. The project proposal was submitted to the Scripps Mercy Hospital Institutional Review Board (IRB) and approved. The project was also submitted to the University of San Diego IRB and approved. Each participant provided verbal consent following an explanation of the project goals during the face-to-face recruitment process. Nurses had the right to refuse to participate in the project or withdraw at any time without penalty. Confidentiality and anonymity of participants were maintained by summarizing and reporting all data in aggregate.

Results

One benefit of the project appeared to be a decrease (though not statistically significant) in the uncomfortable feelings and sense of helplessness nurses experienced when caring for a dying patient (see Figure 4 and Figure 5). This change in feelings may have led to improved

Figure 4

Change in Nurses' Feelings After Education (TS-Q1)

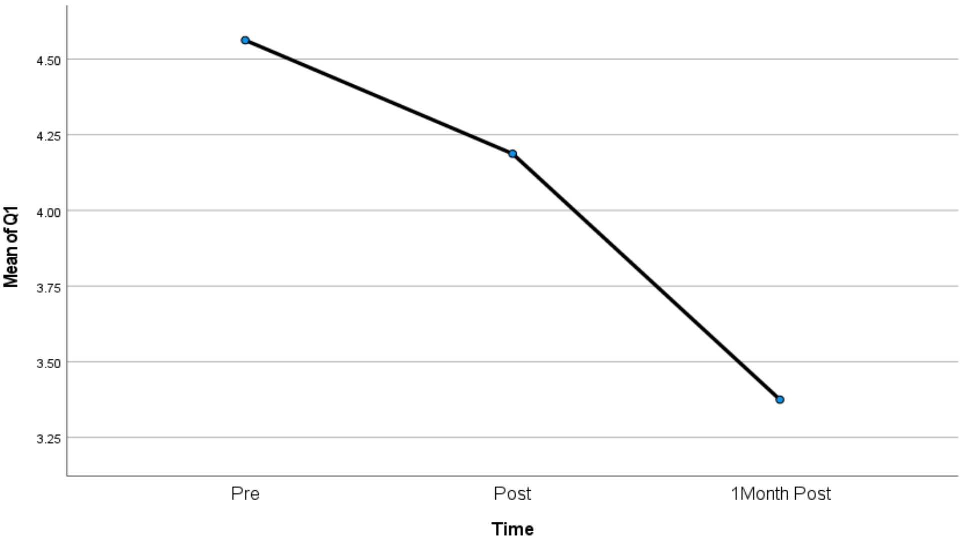
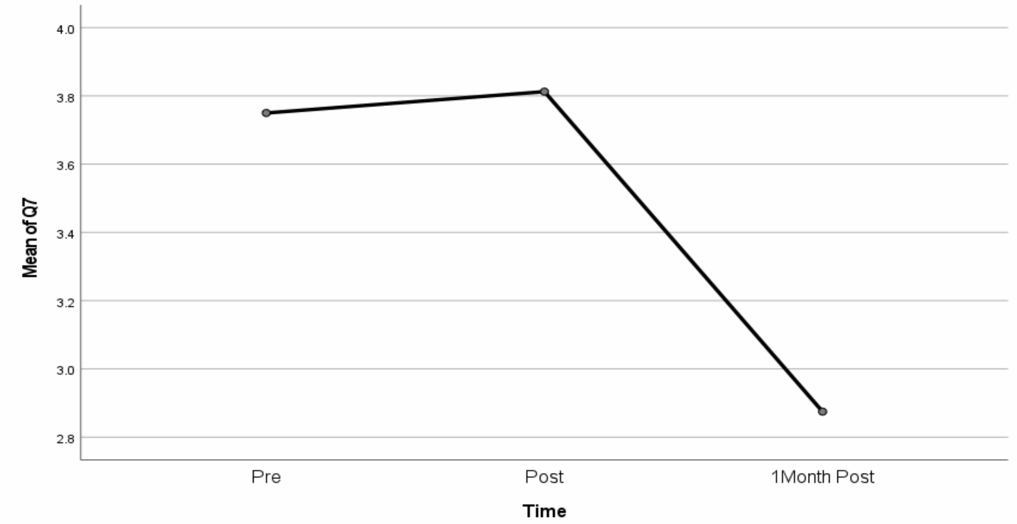


Figure 5

Change in Nurses' Feelings After Education (TS-Q7)



Note. After education, there appeared to be a decrease (though not statistically significant) in the uncomfortable feelings and sense of helplessness nurses experience when caring for a dying patient.

symptom management. Posteducation, there appeared to be an increase in medication doses for symptom management when compared to the same 30-day period the year prior (see Table 1 and Table 2). Due to the low number of overall doses, statistical analysis could not be conducted.

Limitations

A limitation of this project was that eight of the nurses who initially received instruction were lost in the follow-up process and did not complete the 30-day posteducational TS. Due to a low number of comfort care patients, not enough medication doses were given to conduct statistical analysis. Also, this project was implemented on a single unit of an urban hospital during the COVID-19 pandemic, possibly limiting its efficacy and the ability to effectively assess benefits.

Cost-Benefit Analysis

The total cost of this educational intervention for 16 nurses is estimated at $902, or $56.38 per nurse. Although some revenue return is presumed due to increased charges related to increased medication doses, there is no immediate overall financial gain. The connection between reimbursement and patient satisfaction must be considered; theoretically, improved symptom management leads to increased satisfaction at a cost that is not prohibitive to the organization.

Implications for Clinical Practice

This intervention is clinically relevant and easy to replicate in future efforts. EOL symptom management may be improved by providing acute care nurses a 30-minute educational session about use of the CARES tool and basic pharmacology of EOL symptom management medications. Implementation of an asynchronous online format would increase ease of access

Table 1

Use of Medications for Symptom Management (Preintervention)

Age	Gender	Comfort care date	Comfort care time	Discharge or death date	Discharge/death time	Hours on comfort care	Scheduled meds or pump with basal?	Morphine doses	Hydromorphone doses	Oxycodone doses	Fentanyl doses	Lorazepam doses	Midazolam doses	Haloperidol doses	Ondansetron doses	Glycopyrrolate doses	Total PRN doses
94	M	1/11/2021	1539	1/11/2021	2023	5	no	1									1
89	F	1/12/2021	1335	1/12/2021	2100	7.5	no	1									1
83	M	1/27/2021	1320	2/1/2021	1305	>72	yes										0
84	F	1/8/2021	1255	1/9/2021	1930	30.5	no	1									1
90	M	1/9/2021	1207	1/11/2021	1630	52	no	1									1
67	M	1/28/2021	1543	1/29/2021	0820	16	no										0
75	F	1/17/2021	0837	1/17/2021	0925	1	no					1					1
75	F	1/10/2021	1139	1/10/2021	1255	1	no										0
89	M	1/8/2021	1909	1/9/2021	0655	11	yes					1					1

Table 2

Use of Medications for Symptom Management (Postintervention)

Age	Gender	Comfort care date	Comfort care time	Discharge or death date	Discharge/death time	Hours on comfort care	Scheduled meds or pump with basal?	Morphine doses	Hydromorphone doses	Oxycodone doses	Fentanyl doses	Lorazepam doses	Midazolam doses	Haloperidol doses	Ondansetron doses	Glycopyrrolate doses	Total PRN doses
96	M	1/5/2022	0034	1/5/2022	2030	8	no		1								1
84	F	1/31/2022	1349	2/4/2022	1455	>72	yes	1									1
85	M	1/28/2022	1427	1/31/2022	0301	60.5	no									2	2
68	M	1/13/2022	1112	1/14/2022	0438	17	yes	1									1
63	M	1/17/2022	0846	1/17/2022	1734	8	yes			3							3
48	F	1/18/2022	1633	1/22/2022	1400	>72	yes	5									5
94	M	1/21/2022	1404	1/22/2022	1322	23	yes	1				3					4
60	F	1/26/2022	1455	1/29/2022	1648	>72	no	1									1
83	M	1/11/2022	1433	1/19/2022	1600	>72	no					1					1
60	F	1/15/2022	0955	1/17/2022	1740	56	no		7			1			2		10

Note. There appeared to be an increase in medication doses for symptom management after education compared to the same 30-day period 1 year prior.

and minimize the risk of losing nurses to follow-up, as a reminder can be sent to encourage nurses to complete the final TS. It may be valuable to consider additional nursing support to assist in caring for EOL patients, or debriefing after patient death.

Conclusion

This evidence-based intervention influenced nurses' attitudes toward caring for EOL patients by demonstrating a decrease (though not statistically significant) in nurses' self-reported uncomfortable feelings and sense of helplessness when caring for EOL patients, which may have led to improved symptom management. There was an apparent increase in medication doses for symptom management after nurse education, although due to the low number of overall doses, statistical analysis could not be conducted.

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